A close-up photograph of two hands, one dark-skinned and one light-skinned, clasped together, symbolizing care and support.

PUTTING THE PATIENT FIRST

Recommendations for Creating a Vibrant Safety Net System for the People of Nashville
A Report by the Indigent Care Stakeholder Work Team / March 5, 2019



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What does it mean to be indigent?

The medically indigent are among Nashville's most vulnerable citizens. They are uninsured or do not have adequate insurance to cover the cost of their medical expenses and often sacrifice food and other necessities to make ends meet.

Sources: Tennessee Community Catalyst, Hospital Charity Care and Financial Assistance Policy and Procedures.

What is a safety net?

The Institute of Medicine defines the safety net as those providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients.

Source: The Institute of Medicine

Executive Summary

More than 100,000 people in the city of Nashville are considered medically underserved. Members of this group are diverse in age, race, education, occupation, and where they live in Davidson County. Many have jobs; still, they cannot afford comprehensive health insurance. If they get sick, they cannot pay their medical bills. Nashville relies on their contributions to the economy, and they rely on Nashville's safety net system for their health care.

The health care safety net system consists of numerous organizations in the Nashville area:

- Nashville General Hospital at Meharry, the city-funded hospital
- Private hospital systems and providers
- Federally Qualified Health Centers (FQHC)
- Meharry Medical College clinics
- Community and faith-based clinics

The safety net is vital to the greater health of our community; however, it is deeply fragmented, and its effectiveness and efficiency have been increasingly called into question. In November 2017, then-Mayor Megan Barry brought the issue to a head when she announced inpatient services would close at Nashville General Hospital. The decision increased uncertainty and instability in the community. In response, Dr. James E.K. Hildreth, President and CEO of Meharry Medical College, volunteered to form an Indigent Care Stakeholder Work Team to look more deeply at the safety net system in Nashville, and formulate a vision for the future. Because of the college's long-established mission to serve the underserved, Meharry felt a duty – and was uniquely qualified – to lead the conversation about the future of indigent care.

THE STATED PURPOSE OF THE STAKEHOLDER WORK TEAM WAS TO CONCEPTUALIZE AND RECOMMEND A NEW SYSTEM OF INDIGENT CARE THAT LEAVES NO ONE BEHIND.

To ensure that all perspectives were brought to the table, Dr. Hildreth invited representatives of health care and community organizations to join the Stakeholder Work Team. By design, each member of the team approached indigent care from a unique perspective, yet all shared the same goal: to deliver the best possible care to those in our city who need it most.

Charged by our purpose, the Stakeholder Work Team met for the first time on December 18, 2017. Our work has been bolstered by the overwhelming support of the people of Nashville, who voiced in a Vanderbilt University poll in March 2018 the opinion that the city has a responsibility to care for its most vulnerable residents.

For 14 months, the Stakeholder Work Team met in both public and private sessions to study the best options for indigent care in Nashville. Our work included:

- Researching indigent care models and best practices from across the nation;
- Inviting input from local, regional and national experts in the field of indigent care delivery; and
- Hearing testimony from community and civic leaders who value the safety net for health care services.

BASED ON OUR FINDINGS, WE BELIEVE:

- Nashville must become a healthy city for all who live and work here if we are to maintain our vitality, growth and national profile.
- Every resident of Nashville deserves quality health care delivered in an environment that is conducive to healing, regardless of zip code or ability to pay.
- The patient – not the provider – must be the priority and center of the safety net system.
- To truly be effective, the safety net system must address nutrition, transportation, housing, and other social determinants of health that impact a patient's ability to access treatment and heal.
- Nashville's entire health care community must be involved in the system to maximize care for our vulnerable residents, minimize costs, and eliminate duplication of services.
- Nashville's position as a health care capital creates the unique opportunity to tap into the best minds in health care and make our safety net system a model for the nation.

TO THIS END, THE STAKEHOLDER WORK TEAM RECOMMENDS THAT NASHVILLE CREATE AN INTEGRATED SAFETY NET SYSTEM THAT PLACES PATIENTS AT ITS CENTER AND ACTIVELY INVOLVES THE CITY'S ENTIRE HEALTH CARE NETWORK IN THEIR CARE.

The Purpose of the Stakeholder Work Team:

to conceptualize and recommend a new system of indigent care that leaves no one behind.

WHY THIS MATTERS

Cost of indigent care at Nashville's three major hospital systems is calculated at \$153,500,000 annually.

There were an estimated 270,333 emergency room visits in 2017 for the uninsured.

There is no tracking system for uninsured patients, resulting in inconsistent and uncoordinated care.

Fragmentation in the current system focuses on acute care rather than preventive medicine and wellness.

INDIGENT CARE NASHVILLE: A MODEL FOR THE NATION

High-quality, cost efficient, and patient-centered system.

Rooted in imagination, innovation, collaboration, community spirit and service.

Empowered patients who are partners in health care decision making.

Information transparency that is accessible to patients and providers.

WE RECOMMEND THAT THE SYSTEM BE COMPRISED OF TWO CORE ELEMENTS:

- 1** A collaborative network of hospitals and health care providers across the city of Nashville that will deliver integrated, quality, patient-centered care to the uninsured and underinsured, according to their areas of specialty.
 - Nashville General Hospital will serve as the hub of the network, coordinating care with the city's private hospital systems, community-based clinics and social service agencies.
 - Patients can enter the network through any provider within the system and will be directed to the best care options based on their specific medical needs.
- 2** An indigent care management program called BetterHealth Nashville®, which will coordinate the care of Nashville's most vulnerable residents, ensuring that their services are adequately funded, their treatment is tracked and integrated, and their social needs are addressed.
 - BetterHealth Nashville® will be managed by Meharry Medical College, which will coordinate care for eligible patients and engage the Data Science Institute at Meharry to track and manage their medical and social needs wherever they receive care within the network.
 - Patient care will be reimbursed through a newly-formed indigent care fund. Funds will follow the patient wherever they receive care in the network.

AS THE NEXT STEP IN THE PROCESS, WE RECOMMEND THE CREATION OF A NEW NETWORK IMPLEMENTATION TEAM THAT WILL DETERMINE A FISCAL AND OPERATIONAL STRUCTURE TO MAKE THE SAFETY NET SYSTEM VIABLE, SUSTAINABLE, AND SUCCESSFUL.

THE ROLE OF THE PLANNING TEAM WILL BE TO:

- Conduct a detailed gap analysis of the current system to gather and assess current data on who is in need, where they live and work, and the services required.
- Recommend the most effective funding mechanism for the new system by studying best practices, identifying available resources, and testing various financial models.
- Determine the ideal management structure for the new system by examining best practices and testing various management scenarios.
- Assess the infrastructural needs of Nashville General Hospital and recommend a capital improvement program that involves either renovating the existing structure or constructing a new one.

⁶⁶ The safety net is one for people who don't have other kinds of access. It's also absolutely a source of high quality, affordable care for everybody in this community.⁹⁹

COMMUNITY MEMBER AT STAKEHOLDER WORK TEAM LISTENING SESSION



Nashville's Health Care Infrastructure

Nashville, Tennessee is the capital for health care services in the U.S. and is often referred to as the "Silicon Valley" for start-up health care companies. Its rich history in health care began in the mid-1870s with the founding of the Medical Department of Central Tennessee College (Meharry Medical College) and Vanderbilt University Medical Center (Vanderbilt School of Medicine).

Today, Nashville is home to more than 500 health care companies, including 17 publicly-traded corporations, which work locally, nationally and globally, and generate over \$92 billion in revenue and 570,000 jobs. Nashville is also home to nearly 400 professional service firms that provide expertise to the health care industry.

Despite this purchasing power and health care intellectual capital, comprehensive and efficient indigent care in the city is a pernicious, unresolved issue. If we are to maintain our growth and national profile, we must become a healthy city for all who live and work here.

17 publicly traded
health care companies

570,000 global jobs created by
the health care industry

\$92 Billion in annual
revenue

Source: Nashville Health Care Council





1876

Meharry Medical College founded

1890

City Hospital opens; later named
Metro General Hospital

1915

Meharry's Hubbard Hospital
built; moves to North Nashville
in 1930

History of Nashville General Hospital

Nashville General Hospital at Meharry has cared for the people of the Nashville community for more than 128 years. When it first opened as City Hospital on April 23, 1890, with one physician, seven nurses and 60 beds, the hospital's mission was to provide health care services to the desperately ill or those persons unable to care for themselves. It has carried that mission forward to this day.

The history of Nashville General is intricately linked with Meharry Medical College, which was founded in 1876 to train black doctors to treat freed slaves. Meharry was named to honor the Meharry family, which gave more than \$30,000 in cash and real estate to fund the school in thanks for a kindness received from a family of former slaves. Since its founding, Meharry has pursued a singular mission: to serve the underserved. Today it is one of the top five producers of primary care physicians in the nation.

In 1915, the year Meharry Medical College obtained its own granted charter, area citizens raised enough money to erect a hospital honoring the college's first dean and president, Dr. George W. Hubbard. First erected in South Nashville, the George W. Hubbard Hospital moved to North Nashville in 1930. With nowhere else to go for health care, most black people in Nashville turned to Hubbard Hospital until the 1960s.

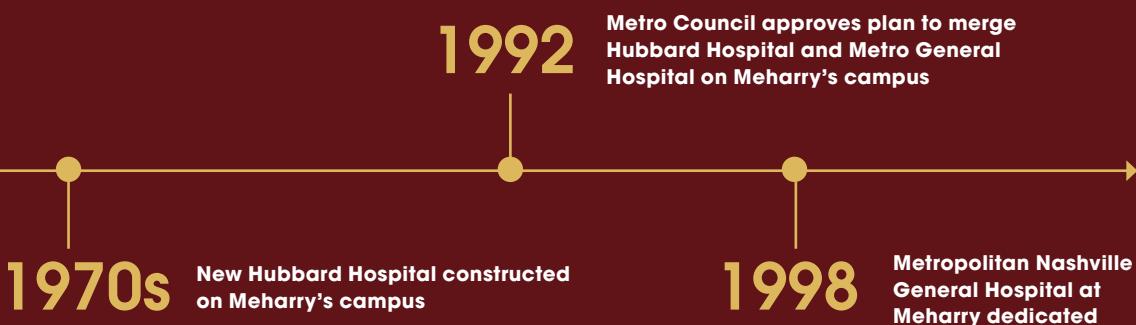
In the late 1970s, Meharry constructed a new Hubbard Hospital, featuring an 11-story tower and 400 bed facility.

A decade later, Meharry's 8th president and future U.S. Surgeon General, Dr. David Satcher, introduced a plan to merge Hubbard Hospital and the city's hospital, then called Metro General Hospital. The plan benefited both institutions. Meharry was considering closing Hubbard Hospital and Metro General Hospital was faced with renovating its 100-year-old facility or building a new hospital.

In 1992, the Metropolitan Council approved the plan. A year later, Meharry Medical College began providing medical services at Metro General Hospital. On January 11, 1998, following renovations to the building, the new Metropolitan Nashville General Hospital at Meharry was dedicated.

For a quarter century, Nashville General Hospital has served as the principle teaching hospital for Meharry's clinical training, with Meharry residents and students providing care to the patients there. Meharry students and residents train in family medicine, internal medicine, occupational medicine, preventive medicine, OB/GYN, and psychiatry at Nashville General Hospital.

The hospital represents a unique public-private alliance between Meharry and the Metropolitan Government of Davidson County to care for the most vulnerable citizens of Nashville.



The significance of Meharry Medical College and Nashville General Hospital to the City of Nashville

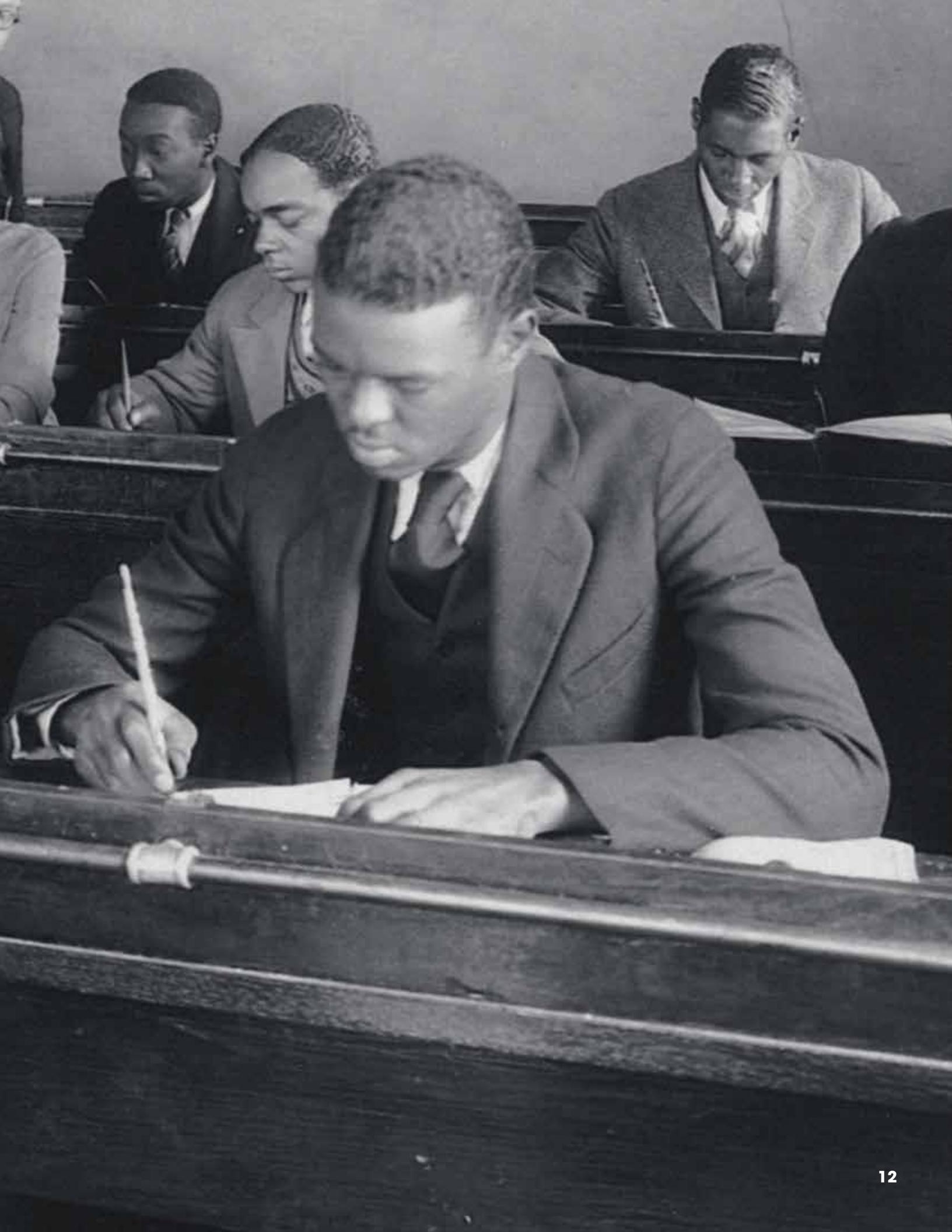
Nashville General Hospital is a primary safety net provider in the city.

Meharry and Nashville General Hospital provide over \$83 million in uncompensated care to the medically underserved of Nashville.

Meharry Medical College's core mission is to serve the underserved.

4 of 5 medical and dental Meharry alumni practice in underserved rural and urban communities.

70% of Meharry medical graduates pursue primary care specialties.



100,000+

residents of Nashville are
uninsured or underinsured.

Current State of Indigent Care in Nashville

According to the Institute of Medicine, a safety net system is made up of “those providers that organize and deliver a significant level of health care and other needed services to uninsured, Medicaid and other vulnerable patients.”

Nashville’s safety net system includes one public and three private hospital systems, three Federally Qualified Health Centers (FQHC), and multiple community and faith-based providers. Thirty-five sites in Middle Tennessee provide outpatient care to the medically underserved. More than 100,000 residents rely on this system for their health care.

Yet Nashville’s safety net is overwhelmingly fragmented, relies heavily on inpatient versus outpatient care, lacks significant capital investment, and is currently undergoing political scrutiny. There is no process in place to track the services that hospitals and clinics provide to vulnerable

patients, leaving them with inconsistent and uncoordinated care. Nashville General Hospital and Meharry Medical College provide \$83 million in uncompensated care to the uninsured or underinsured each year. Additionally, Nashville’s three hospital systems – HCA Healthcare, Ascension Saint Thomas Health, and Vanderbilt University Medical Center – provided more than \$153 million in uncompensated care to the uninsured or underinsured in 2016 alone. Such expenses tax both the city of Nashville and the hospitals that must carry the load.

Over the years, it has become increasingly clear that Nashville needs a newly designed indigent care system that is more centralized and seamless. However, discussions on the care and financing for the medically underserved in Nashville have been contentious.

“We are questioning whether or not we should be doing indigent care, which seems so backwards. If you have people who are your own, you take care of your own.”

COMMUNITY MEMBER AT STAKEHOLDER WORK TEAM LISTENING SESSION

MARKET CONDITIONS



Over 100,000 residents of Nashville – or 15% of the population – are uninsured or underinsured.



According to Perception Health, the three major hospital systems in Nashville provided over \$150M of uncompensated inpatient care in 2016.



In 2016, the 35 safety net organizations in Nashville/ Davidson County provided care to 109,448 patients in 339,451 visits.

The population at risk of being classified as indigent and thus requiring free or subsidized care:

Homeless	2,365
<\$15,000:	36,553
\$15-24,999:	30,446
\$25-34,999:	31,069
Total Indigent Population.....	109,448
Population of Davidson County	697,945
Total Indigent Population as Percent of Total.....	15.6%

Source: Perception Health

NASHVILLE GENERAL HOSPITAL

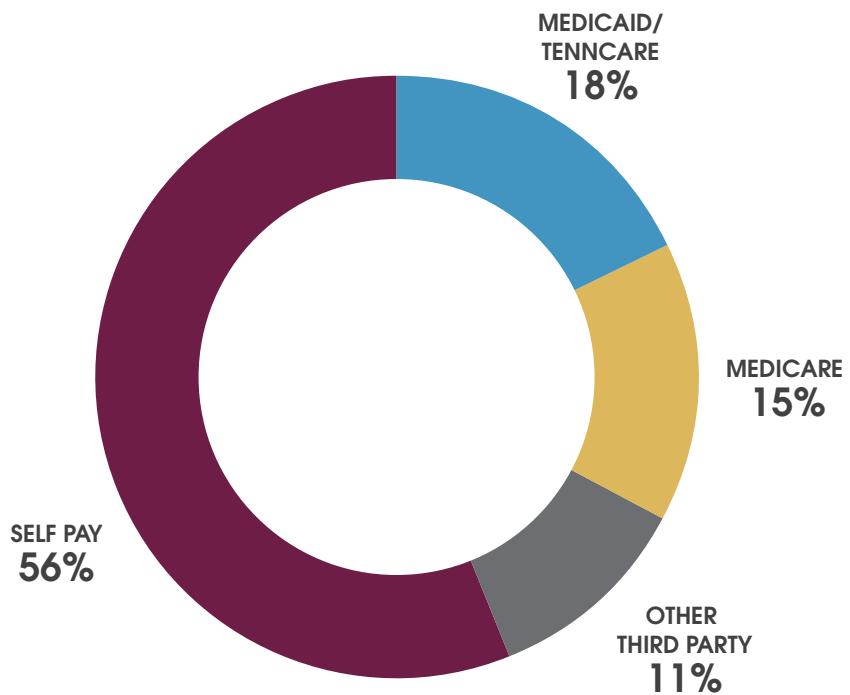
The uncertain status of Nashville General Hospital is a constant theme in the discussions about indigent care in Nashville. Nashville General maintains 114 licensed beds and 546 employees. It reported 26,410 ER visits, 2,454 inpatient admissions, and 40,621 outpatient visits in 2018. In partnership with Meharry Medical College, Nashville General provides approximately \$83 million in uncompensated care each year. Meharry Medical College alone provides over \$26 million of that.

Three of Davidson County's top ten zip codes for uninsured residents receiving inpatient and emergency services in Davidson County are adjacent to Nashville General Hospital. Nashville General Hospital provides the bulk of uninsured care for specialty populations as well, including patients from the Tennessee Prison for Women, Riverbend Maximum Security Institution, and the Turney Center Industrial Complex.

Metro Government provides a subsidy of approximately \$35 million per year to Nashville General Hospital to defray the cost of caring for the high number of medically underserved patients who visit the hospital. Yet in recent years, this level of city funding has not been sufficient to cover expenses at the hospital. Consequently, Metro has had to approve emergency funding to stabilize Nashville General Hospital.

In the meantime, the patient volumes at the hospital have fallen, threatening Meharry residents' training in certain service lines. In November 2017, then-Mayor Megan Barry proposed cutting costs by closing inpatient care at the hospital. Rather than stabilizing the situation, the proposal created further uncertainty and concern in the community served by Nashville General Hospital.

NASHVILLE GENERAL HOSPITAL PAYER MIX



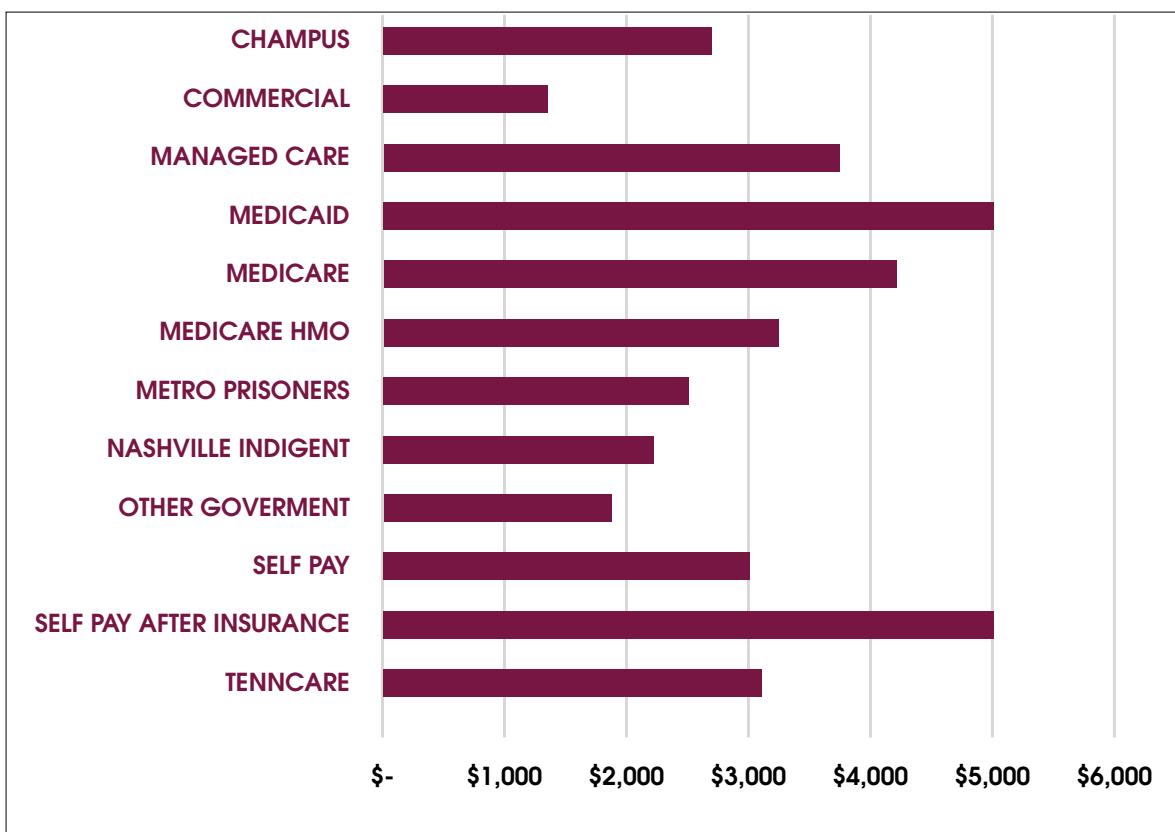
Source(s): Nashville General Hospital, June 30, 2017 Audit Report

METRO GENERAL HOSPITAL

MEH



AVERAGE CHARGE PER PATIENT



Source(s): Data from 2017 Medicare Cost Reported in October 2017, Perception Health 2018

Number of licensed
beds at top
Nashville area
hospitals

**ASCENSION SAINT
THOMAS MIDTOWN**

683

**TRI-STAR
CENTENNIAL**

686

VANDERBILT

1025

NASHVILLE'S THREE MAJOR HOSPITAL SYSTEMS

Three major health systems – HCA Healthcare, Ascension Saint Thomas Health, and Vanderbilt University Medical Center—play an important role in caring for the medically underserved.

Critical Nashville area hospitals in these systems include:

ASCENSION SAINT THOMAS MIDTOWN HOSPITAL, a nonprofit, has more than 36 service areas, including general wellness centers, emergency care, wound care, obstetrics and gynecology, behavioral health, cardiology, pulmonology, gastroenterology, nephrology, endocrinology, neurology, rheumatology, orthopedics, radiology and pharmacology. As of 2017, Ascension Saint Thomas Midtown maintained 683 licensed beds, 2,901 associates and affiliated physicians, 47,146 ER visits, 15,163 surgeries, and 195,183 outpatient visits.

TRI-STAR CENTENNIAL MEDICAL CENTER, a for-profit HCA Healthcare hospital, offers medical and surgical programs including behavioral health, 24-hour emergency care, cardiology and vascular care, radiology, neurology, oncology, orthopedics, pediatrics, rehabilitation, sleep disorder care, and women's services. As of 2017, Centennial maintained 686 licensed beds, 4,100 staff and physicians, 32,500 patient admissions, and 87,500 ER visits each year.

VANDERBILT UNIVERSITY MEDICAL CENTER (VUMC), a nonprofit, is the only Level 1 trauma center in the Nashville Metropolitan Area. Its service lines include neurology, ophthalmology, otolaryngology, cardiology, pulmonology, gastroenterology, urology, oncology, obstetrics & gynecology, pediatrics, orthopedics, transplants (hepatic, general, trauma, vascular), and anesthesiology. As of 2016, VUMC maintained 1025 licensed beds, 20,235 employees, 123,632 ER visits, 57,421 surgeries, 1,903,548 outpatient visits.

THE SAFETY NET CONSORTIUM OF MIDDLE TENNESSEE

The Safety Net Consortium of Middle Tennessee, a nonprofit, was founded in 2000 to help the medically underserved of Nashville access the services of the safety net system. The Consortium brings together clinics, providers, academicians, consumers, and community leaders to integrate knowledge and skills supporting the safety net and improve patient care. The Consortium's "Project Access Nashville" and "Project Access Nashville - Specialty Care" programs have led to more than 62,000 individuals finding a medical home and over 4,700 accessing specialty care.

MEMBERS OF THE SAFETY NET CONSORTIUM

ASCENSION SAINT THOMAS HEALTH	MEHARRY MEDICAL COLLEGE	NASHVILLE ACADEMY OF MEDICINE
CENTERSTONE	MEHARRY VANDERBILT ALLIANCE	NASHVILLE GENERAL HOSPITAL
CHARIS HEALTH CENTER	MENTAL HEALTH AMERICA OF MIDDLE TENNESSEE	NEIGHBORHOOD HEALTH
CONNECTUS HEALTH	MERCY COMMUNITY HEALTHCARE	SALVUS CENTER
FAITH FAMILY MEDICAL CENTER	METRO PUBLIC HEALTH DEPARTMENT	SILOAM HEALTH
HOPE CLINIC	MIDDLE TENNESSEE ORAL HEALTH COALITION	NEIGHBORHOOD HEALTH
INTERFAITH DENTAL CLINIC	TENNESSEE DISABILITY COALITION	
MATTHEW WALKER MEDICAL CLINIC		

Project Access Nashville



Project Access Nashville
Specialty Care



62,000

individuals finding
a medical home

FEDERALLY QUALIFIED HEALTH CARE ORGANIZATIONS



MATTHEW WALKER
Comprehensive Health Center, Inc.

MATTHEW WALKER COMPREHENSIVE HEALTH CENTER

Provides primary medical care, behavioral health services, dental care and health education to approximately 17,000 people annually in Nashville, Clarksville and Smyrna, Tennessee.



NEIGHBORHOOD HEALTH

Described as "Nashville's Family Doctor"; provides family medical care, a 24-hour call-line, preventive, urgent and chronic care, lab tests, and prescriptions.



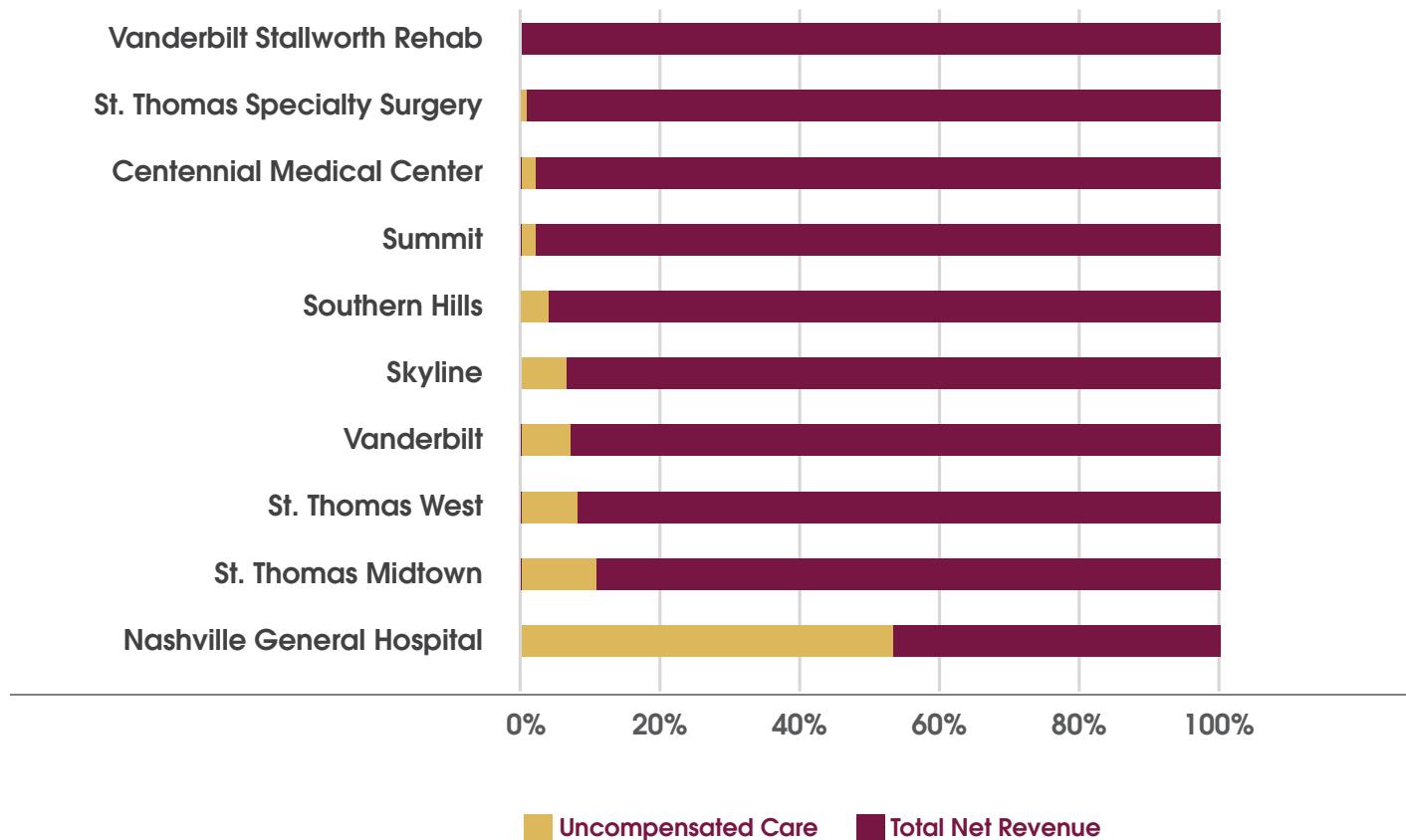
CONNECTUS HEALTH

A nonprofit community health care organization that helps manage the health care of the entire family and community, including individuals who are underinsured or lack insurance.



Share of Uncompensated Inpatient Care

Though the three private hospital systems have created programs to assist patients who have difficulty paying for care, Nashville General Hospital provides the highest percentage of charitable care in the city. According to the 2016 Annual Report of the Tennessee Hospital Association, Ascension Saint Thomas Midtown contributed 3.8% of its total inpatient care in a charitable capacity, Centennial contributed 0.3%, and Vanderbilt University Medical Center contributed 3.5%. In the same year, Nashville General Hospital topped all Davidson County hospitals with 18.4% charitable care.



Source(s): Data from 2017 Medicare Cost Report in October 2017, Perception Health 2018

TOTAL UNCOMPENSATED COST OF INPATIENT HOSPITAL CARE



Source(s): Data from 2017 Medicare Cost Reported in October 2017, Perception Health 2018

Indigent Care Stakeholder Work Team

OVERVIEW

In response to community concern about then-Mayor Megan Barry's 2017 announcement to close inpatient care at Nashville General Hospital, Meharry President and CEO Dr. James E.K. Hildreth volunteered to form an Indigent Care Stakeholder Work Team to look more deeply at the system in Nashville. Because of the college's long-established mission to serve the underserved, Meharry felt a duty – and was uniquely qualified – to lead the conversation about the future of indigent care.

To ensure that all perspectives were brought to the table, Dr. Hildreth invited representatives of health care and community organizations to join the Stakeholder Work Team. By design, each member of the team approached indigent care from a unique perspective, yet all shared the same goal: to deliver the best possible care to those in our city who need it most.



THE TENNESSEAN

Nashville General to end inpatient care, Mayor Megan Barry announces

Mayor Megan Barry delays closure of inpatient care at Nashville General Hospital

Meharry to hold "listening session" amid uncertainty about Nashville General's future

The Stakeholder Work Team convened to identify strengths and gaps in the safety net system in Nashville.

Since December 2017, the Stakeholder Work Team has met in public and private sessions to assess the current system and research other models for indigent care delivery. Members of the full Work Team met monthly in executive session to define parameters of their assignment, report on research and progress, and deliberate recommendations. Additionally, the Work Team engaged in the following activities:

- *Community Engagement:* The Work Team ensured transparency and community input with an outreach plan that included:
 - A dedicated website: www.home.mmc.edu/stakeholder-mission where the Work Team posted its findings and solicited community feedback.
 - Six community listening sessions at locations throughout the city where members of the greater community provided input about their concerns and desires surrounding health care.
 - A case competition in which graduate students at the Milken School of Public Health at George Washington University were invited to study the system and present their insights and recommendations on the future of indigent care in Nashville.
- *Models of Care Committee* – The Work Team tasked this committee with assessing Nashville's current Safety Net System and examining exemplary models of indigent care delivery in other cities to inform the creation of a system in Nashville.
- *Funding Models Committee* – The Work Team tasked this committee with exploring national funding models.

The following are major themes that arose throughout the year of Stakeholder Work Team study:

1

CUSTOMER SEGMENTS

Who needs to be served? (Insured? Uninsured? Residents? Other?)

FEEDBACK

Everyone

Homeless, students, working poor, immigrants, incarcerated

Start broadly to include everyone and then narrow it down to set parameters on geographic boundaries

2

VALUE PROPOSITION

What are the customer needs to be satisfied? What is most important to you about this process?

FEEDBACK

Seamless integration regardless of ability to pay

Stable source of care connected to social determinants of health

Systems approach to electronic medical records (EMR)

Adequate communication at the level patients can understand

Improved health education/lifestyle habits

Preventive care/wellness

Management of chronic conditions

Emergency, primary, and specialty care

Convenient and timely access to care

3

KEY ACTIVITIES

What should be the core, fundamental activities provided? What are the service gaps?

FEEDBACK

Transportation, access, care coordination, primary ambulatory care that is culturally competent, planning and resource allocation process

Communication to patients about where to go to access care and costs of health care

Electronic Medical Record/shared health data among providers

Service gaps: interpreters, health literacy, mental health, linkage to service, access to specialists, continuity of care, language barriers, chronic and preventive care

4

PARTNERS

Who are the key strategic partners? What will these partners bring to the table?

FEEDBACK

Nashville General Hospital	Meharry Health Science Educators	Community advocates that provide direct services
Physicians	FQHCs	Faith-based clinics
City government	State/Federal/CMS	Business community
Insurers	Patients	Medical schools
Community (educational institutions, religious organizations, etc.)	Employees	Nashville Technology Council
Three major hospital systems	Prisoners	Metropolitan Transit Authority
	Mental health organizations	

5

DELIVERY

How should we deliver services and interact with stakeholders?
(pre-service, point-of-service, and after-service?)

FEEDBACK

Technology driven	Clinic, acute care, chronic care	Service standards: language, hours,
Messaging	Inclusion of hours of operation	Clinic, virtual, app, palliative care, ongoing communication
Community leaders		
Tech, data, brain power	Services should be integrated	
Media		

KEY RESOURCES

What key resources does our value proposition require?

REVENUE STREAMS

What are the sources of funds that will make a sustainable system and how do we capture these funds?

Technology	Leaders from like-models that have succeeded	TennCare/Private Insurance	Beta testers
Interoperability	Funding	Payers	Centennial
Infrastructure	Community buy-in and advertising of services	Community Foundation of Middle Tennessee	Vanderbilt
Providers	Up-to-date equipment	Grants	Ascension Saint Thomas
Funding		Commonwealth Group Foundation	Metro Employee Health Plan
Data and modeling expertise		CMS Innovation Fund	Dedicated Local Tax
Information systems		City/State Government	Charitable gifts
Political will (political buy-in from city and state leaders)		Business/Entertainment Industry	Appropriate metro funds to fill gaps

Community Engagement

The Stakeholder Work Team developed an outreach plan for the community and other stakeholders to ensure that members of the public were regularly and fully informed about the progress of its work, and to provide ample opportunity for them to give their perspectives and input on the discussions. The plan aided in the intentional inclusion of community members amidst a low-trust social and political climate.

A key component of the outreach plan was a series of six community listening sessions, allowing Davidson County residents an opportunity to provide feedback about then-Mayor Barry's announcement, as well as input on ways to move forward.

The following are the dates and locations of the listening sessions and major themes that emerged:

DATE	LOCATION
January 24, 2018	First Baptist Church Capitol Hill
February 15, 2018	Meharry/Vanderbilt Alliance Safety Net Consortium
February 15, 2018	Olive Branch Church
March 3, 2018	Salahadeen Center and Mosque of Nashville
April 21, 2018	Coleman Park Community Center
June 19, 2018	First Baptist Church Capitol Hill

THE IMPORTANCE OF NASHVILLE GENERAL HOSPITAL AND MEHARRY

"Not only is Meharry an important part of taking care of the most important people, which are indigent patients, but they train doctors who do the same thing."

"There is not another hospital in the state of Tennessee that can do what Meharry Medical College or Nashville General will do – not can do, but will do."

"This is about the people in our community who are generally overlooked, but Meharry has always been there for them."

"General Hospital, in the past they give great service to the Kurdish community. They give good service to people who don't have insurance. I can't pay my bill, but monthly, I pay. They saw my income was low. So, they found the resources to cover my bills. They did."

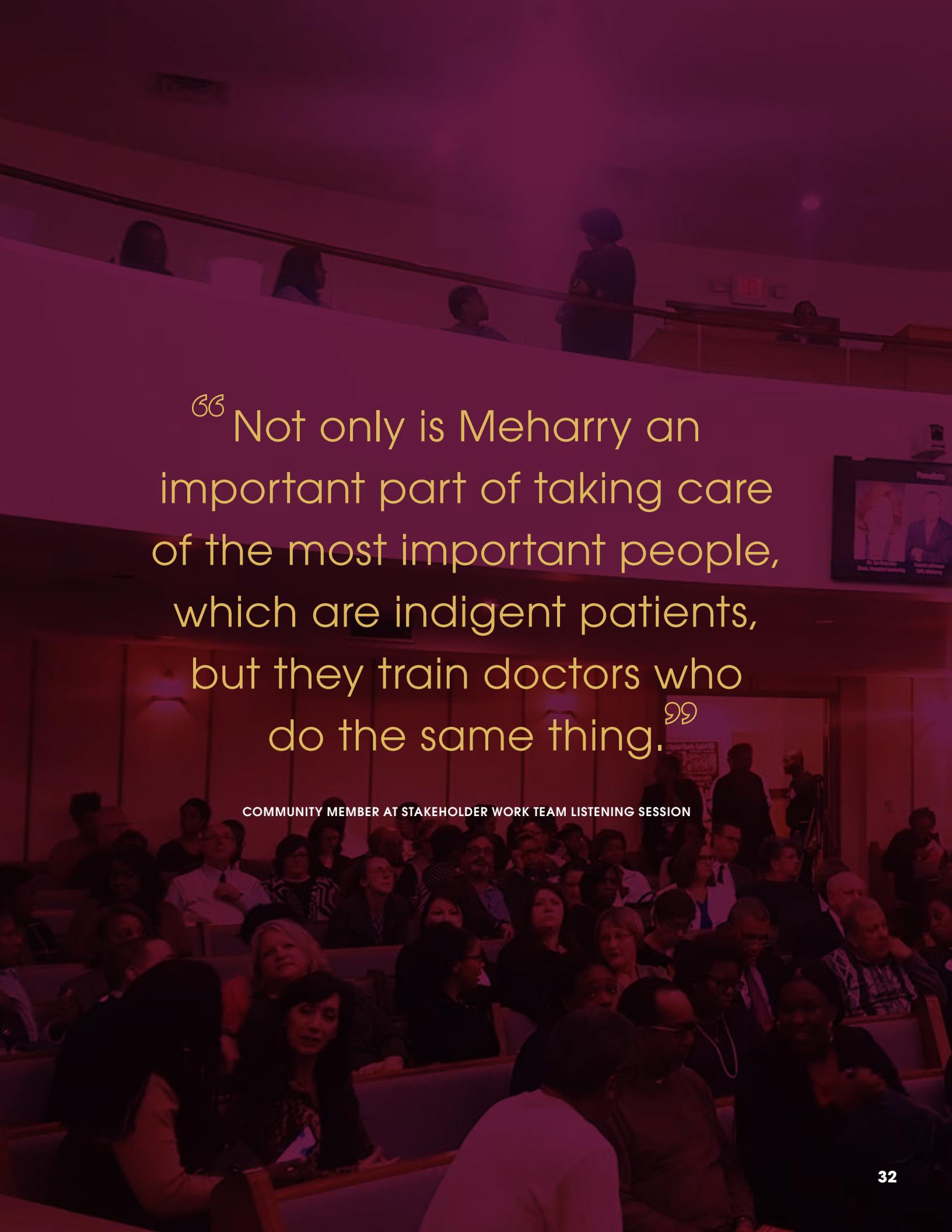
CITY OF NASHVILLE'S ROLE

"What we're dealing with is the by-product of a systematic failure on the part of the leadership of this city to address the issue of General Hospital and the issue of Meharry Medical College."

"This is (a)... defining issue that will give this community an opportunity to deal forthrightly with the things that have systematically undermined and hurt us and kept us from being the city that we have the opportunity to be."

"The word on the street is also that we pay taxes but our taxes are not equitably given to health care and particularly for indigent individuals in our community."

"We are questioning whether or not we should be doing indigent care, which seems so backwards. If you have people who are your own, you take care of your own."



“Not only is Meharry an important part of taking care of the most important people, which are indigent patients, but they train doctors who do the same thing.”

COMMUNITY MEMBER AT STAKEHOLDER WORK TEAM LISTENING SESSION

NASHVILLE GENERAL HOSPITAL BUDGET

"Historically, what the mayor submits to the Metro Council is lower than what the hospital has said they needed. So, when that happens over a period of time, then in my humble opinion, you have set this entity up to fail."

"It's just that every budget is a matter of priorities and the priorities are set by politics and typically, in the city of Nashville at the local level, health has not been a major political priority."

"Our problem is that we don't have money to market. We don't have money to buy the most comfortable beds. We have been given around the same money since 1998. We are working in 2018 with a 1998 budget."

"You are looking at Nashville General like it has the financial capabilities of an HCA or an Ascension Hospital, and we don't. We haven't been properly funded for years."

"Health care services is probably less than 5% of the total Metro budget."

CARE FOR THE POOR

"I think people have a sense when you see these uncompensated care numbers presented, that these other hospitals are doing all of this free care. They are, but 99.9% of it is coming from patients who present in the Emergency Department. So, they are not walking into Centennial or Ascension Saint Thomas and saying, 'I have cancer. Can you give me chemotherapy?' (That's) going to be a short conversation."

"Lots of times we think that people are indigent because they did something wrong, but I didn't do anything wrong. I just got sick."

"What's really important in a lot of the talk that goes on these days, is to remember that two thirds of people who are living in poverty in this community are working."

"The safety net is a safety net for people who don't have other kinds of access. It is also absolutely a source of high quality, affordable care for everybody in this community."

CONTINUITY OF CARE

"Every hospital—public, private, nonprofit—has a responsibility under EMTALA to take care of patients who present in the emergency department, but once that patient's crisis or medical condition is stable, they no longer have an obligation, they can discharge that patient."

"It really goes back to all those social determinants of health. When you are discharging somebody to a place that's not healthy or safe, then it doesn't work."

"One of the pieces that has really fallen to the wayside for our patients is that follow-up care that they desperately need."

"We must streamline processes for our patients to figure out how to allow for admission/ discharge and transfer (ADT) of information."

"I want to echo what the doctor said about continuity of care. That's very important. I work in the clinics and we cannot do what we do without the hospital."

"We kill a lot of trees in this town because we have no common eligibility process."

INTEGRATED CARE

"From the perspective of oral health in our city, it's still grossly under-funded. It is still in the top 2 or 3 of top needs when people are asked about their overall health."

"It's not just primary care. It is primary care, with behavioral health; with oral health; with a nutritionist; with the pharmacy; with all of that integrated together that makes the work that we do work."

"The most expensive people served by Metro General, by Saint Thomas, by Vanderbilt, they've got mental illness on top of diabetes or some other chronic health condition."

"There is a 300% increase in costs when caring for a patient that has a co-morbidity (hypertension, diabetes, and alcoholism) along with some other kind of issue in addition to behavioral health."

"There is no health without mental health. People are not well and cannot be healthy without good mental health."

KEY THEMES OF COMMUNITY LISTENING SESSIONS

Nashville General Hospital and Meharry are important and valued.

Nashville has an obligation to care for vulnerable citizens.

Nashville General Hospital's budget is inadequate to care for the poor.

Coordination of care is important to health outcomes.

Integrated care is imperative.

Models of Care Committee

CONSENSUS WORKSHOP

The Models of Care Committee examined the systems of care in Nashville, explored successful models in other communities, and made recommendations to the Stakeholder Work Team. The committee held a consensus workshop to define key goals, assess the current system, and look at sustainable models around the country.

The facilitated consensus workshop focused conversations on the current and ideal state of Nashville's safety net system. The committee sought to answer the following question:

- How might Nashville create a system of care in Davidson County that leaves no one behind?

The conversations emphasized current assets, challenges, and opportunities within Nashville's safety net system, and how to develop a more coordinated and integrated system.

The framework involved participating in a collective, integrated thinking process to create a shared vision for indigent care. In preparation for the meeting, several items were sent to the group to review, including models of care from other municipalities and the John Snow, Inc. report, which was commissioned in 2010 by Metro Nashville and Davidson County Government to assess care alternatives for Nashville's medically underserved residents. The group provided feedback on its initial assessment of these items. Seven primary points of interest emerged:

- Importance of a dedicated funding source
- Plan that integrates hospitals, Federally Qualified Health Centers and public health
- Incentives for the entire system to work together
- Amount of TennCare dollars received
- Population Health approach and inclusion of social determinants of health
- Broadened specialty care
- Implication of Medicaid Expansion

The committee agreed to change its task from "How might Nashville create a system of care that leaves no one behind?" to "What incremental changes/enhancements to the current system of care would set in motion a system that leaves no one behind?"

The facilitator asked each of the seven participants to write down 10-15 essential incremental changes to the current system. The participants were then separated into two groups, to discuss essential elements and identify the most salient.





A summary of potential enhancements to the current system by Models of Care Committee:

1

OPTIMIZE ACCESS

Increase access to sub-specialty care.

Increase utilization of sub-specialty Advanced Practice Professionals in Federally Qualified Health Centers.

Increase utilization of telemedicine to improve access to care.

Integrate behavioral health into care.

2

GO UPSTREAM

Ensure community-wide health education, including how patients can access care.

Incentivize investment in social determinants of health.

Improve patient access to transportation.

3

CARE COORDINATION

Utilize community health workers/navigators.

Coordinate between acute care and public health professionals.

Create community-wide database of resources for uninsured and underinsured.

Triage to most appropriate provider type.

4

CONNECTED CARE

Establish tech-enabled shared standards for medical homes.

Create shared “core” Electronic Health Record-lite.

Admission/Discharge/Transfer (ADT) system.

5

COMMON ELIGIBILITY

Create shared process determining eligibility for enrollment.

Establish universal qualifying system.

6

FOCUSED COLLABORATIVE SOLUTIONS

Ensure focused collaboration on high-spend conditions.

Pilot program/defined by service and diagnosis.

Further define “highest and best use” of existing assets.

7

PLANNING & STRUCTURE

Create centralized leading and planning entity that is integrated and involves key stakeholders.

Establish an authority/body to facilitate forward progress.

Implement “standing” structure to coordinate inter-system continued collaboration.

Establish shared plan to address community-identified needs.

Create partnerships to train a more culturally-competent workforce.

Encourage investment and engagement of private industry.

RESEARCHED INDIGENT CARE MODELS

The Models of Care Committee also researched safety net systems that have been identified as providing exemplary care to the uninsured and underinsured. The following is an overview of the programs the committee reviewed.

HILLSBOROUGH COUNTY HEALTH CARE PLAN (HCHCP) *Tampa, Florida*

OVERVIEW:

The Hillsborough County Board of County Commissioners created the Hillsborough County Health Care Plan (HCHCP) in 1991 to provide a reliable source of funding for the delivery of health care to low-income, uninsured residents.

- Funding: a ½ cent sales tax, deposited into a Health Care Trust Fund.
- Eligibility: Residents who do not qualify for the Affordable Care Act, Medicaid, or any other insurance, and with incomes at or below 125% of the poverty level, qualify. A resident must also be a U.S. citizen or documented legal representative of the U.S.

THE HCHCP IS IMPORTANT TO THE HILLSBOROUGH COUNTY ECONOMY:

- In FY 2016, HCHCP provided approximately \$90 million to community health care providers.
- HCHCP has 12 hospitals, 31 primary care clinics, over 3,000 participating medical specialists, and a host of ancillary services.

THE HCHCP IS OVERSEEN BY THE HILLSBOROUGH COUNTY HOSPITAL AUTHORITY BOARD THAT HAS RESPONSIBILITY FOR:

- Monitoring the lease permitting Florida Health Sciences Center, Inc. to occupy the Authority's Davis Island property, and transferring ownership and operation of Tampa General Hospital.
- Monitoring the hospital's overall condition, indigent and charity care reports, and minority business enterprise (MBE) contract participation.
- Reviewing grievances by citizens who feel they were denied care due to the inability to pay.

OUTCOMES FROM HCHCP HAVE BEEN POSITIVE:

- From 2006 to 2016, HCHCP served more than 260,000 residents with an estimated positive economic impact of over \$1 billion.
- HCHCP experiences an annual \$23 million savings in ER costs due to community partnerships.
- HCHCP serves approximately 18,000 unduplicated members per year and has an average monthly enrollment of 13,000.
- There has been a 5% average annual growth in pharmacy claims since 2013 and 89% average HCHCP utilization by enrolled HCHCP members.

CONGREGATIONAL HEALTH NETWORK (CHN)

Memphis, Tennessee

OVERVIEW:

The Congregational Health Network (CHN) is a partnership established in 2006 between Methodist Le Bonheur Health and nearly 400 churches in Memphis, Tennessee to improve health education of local parishioners and help them seek proper care through the Methodist Health System.

THE NETWORK INVOLVES BOTH HEALTH SYSTEM EMPLOYEES AND VOLUNTEERS:

- Navigators employed by Methodist Le Bonheur Healthcare train at least two volunteer liaisons per congregation on the basic services provided by the health system.
- These liaisons connect the patient to health resources.
- Navigators work with each patient from admission to post-discharge.

OUTCOMES OF CHN HAVE BEEN POSITIVE:

- More than 12,000 congregants are enrolled in the program.
- A recent study found that the mortality rate of CHN members was nearly half the rate of non-enrolled patients with similar characteristics.
- The same analysis showed CHN members had lower health care costs than non-participants.
- CHN members had a lower inpatient utilization and a higher satisfaction level with the Methodist Health Care system.





CENTRAL HEALTH MEDICAL ACCESS PROGRAM

Austin, Texas

OVERVIEW:

Established in 2005, the Medical Access Program (MAP) by Central Health in Austin, Texas covers primary care, prescriptions, specialty care, and hospital care for low income Travis County residents.

THE PROGRAM INVOLVES A HOSPITAL HUB THAT IS SUPPORTED BY OTHER PROVIDERS:

- Medical care is provided at CommUnityCare Health Centers and other contracted providers in the community.
- Hospital care is provided at Dell Seton Medical Center at the University of Texas.
- MAP services include in-network physician services, hospital care, outpatient care (including specialty care), x-rays, lab services, emergency care, home health care, durable medical equipment, prescription drugs, dental services, and emergency transportation. Some services require pre-authorization.
- Enrolled individuals receive a MAP ID Card for health care services through any participating clinics or doctors.

PUBLIC-PRIVATE PARTNERSHIP IS ESSENTIAL TO MAP:

Dell Seton Medical Center is a privately-owned hospital on public land. Dell Seton Medical Center is owned and operated by the Seton Healthcare Family. The University of Texas leases the property to Central Health, Travis County's health care district, which subleases it to Seton.

The region's newest hospital, Dell Seton is the primary teaching hospital for UT's Dell Medical School. It is a Level 1 trauma center with 42 trauma beds, 13 operating rooms, 211 patient rooms (with capacity to add up to 135), 517,000 square feet, and a \$310 million price tag for design and construction.

2017 OUTCOMES:

- 150,800 people received health care services (+7,800 year-over-year).
- 75,737 people received screening and assistance for coverage (+5,061 year-over-year).
- 1,524 people received health insurance premium assistance.
- Annual safety net primary care visits have more than doubled since inception (2005).

- MAP enrollment reached 44,397 in FY 2017, an increase of 2,743 from the previous year.
- MAP provider network expanded to 20 new locations throughout Central Texas in 2017.

LIVE WELL SAN DIEGO

San Diego, California

OVERVIEW:

Live Well San Diego was adopted by the San Diego Board of Supervisors in 2010 to work with over 300 "recognized partners" to build a better service delivery system, support positive choices, pursue policy and environmental changes, and improve the overall culture of health in San Diego.

THOUGH THIS MODEL DOES NOT DIRECTLY ADDRESS THE INDIGENT POPULATION, OUTCOMES HAVE BEEN POSITIVE:

- The program's partners are comprised of business, government, faith-based, and education organizations.
- The number of partners increased to 124 in FY2015, compared to 51 the previous year.
- More than one million San Diegans were added to the Live Well San Diego network with the addition of two hospital systems, increasing the total participating hospitals and medical facilities to 21.

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

State of Arizona

OVERVIEW:

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, contracts with several health plans to provide covered services.

THE HEALTH PLAN FUNCTIONS LIKE AN HMO:

- An AHCCCS health plan works with doctors, hospitals, pharmacies, and specialists to provide care.
- AHCCCS helps citizens schedule provider appointments, physical exams, immunizations, prenatal care, hospital care, and prescriptions.

AHCCCS IS DRIVEN BY INNOVATION:

AHCCCS operates under a Section 1115 Research and Demonstration waiver, which allows it to experiment with coverage and care delivery.



AHCCCS lists several initiatives targeting the reduction of fragmentation of health care services across Arizona. These include care coordination and integration, payment modernization, health information technology for communications, developing private sector partners, targeted investments incentivizing providers, and electronic visit verification.

OUTCOMES HAVE BEEN POSITIVE:

AHCCCS reported 2,827,495 unduplicated enrollees for FY 2017, an increase of 109,681 from the previous year.

BOSTON HEALTH CARE FOR THE HOMELESS PROGRAM (BHCHP)

Boston, Massachusetts

OVERVIEW:

The Boston Health Care for the Homeless Program (BHCHP) started in 1985 with a grant from the Robert Wood Johnson Foundation and the Pew Charitable Trust. The program began as a four-year pilot program and developed into a cost-effective, national model of providing comprehensive health care to more than 11,000 vulnerable men, women, and children each year.

BOSTON HOSPITALS RELY ON THE PROGRAM:

- Through BHCHP, vulnerable patients are kept alive and get help for chronic diseases like diabetes, hypertension, and cancer.
- Boston's hospitals depend on BHCHP as an alternative to the emergency room as well as a safe discharge location for medically vulnerable patients.
- Services provided by BHCHP include adult primary care, behavioral health, family services, medical respite care, oral health services, and specialized services (which includes HIV care, Hepatitis C services, substance abuse disorders services, and transgender services).

THE PROGRAM HAS DIVERSE FUNDING

AND PARTNERS:

- BHCHP's budget is approximately \$50 million; about 75% of that comes from third party reimbursements from MassHealth, Medicare, and Health Safety Net.
- The remainder of the funding comes from grants and philanthropy.
- BHCHP's partnerships include members of the hospital, shelter, government, and nonprofit communities.

OUTCOMES HAVE BEEN POSITIVE:

- Started as a four-year pilot program, BHCHP has developed into a national model providing comprehensive care to more than 11,000 men, women, and children each year.
- Total revenue in FY2016 reached \$56,596,611, compared to \$49,476,332 in the previous year.
- Since 2003, BHCHP has had a more than 110% increase in patients accessing oral health services.

SUMMARY

The programs reviewed by the Models of Care Committee have several features in common:

- All systems had member agreement on the definition of the safety net with a common vision and goals as part of multi-year strategic plans.
- Performance and accountability of the systems were aligned with the overall safety net system goals.
- All systems had organized, cohesive systems of care.
- All systems provided or arranged for primary care services for their target populations.
- Most systems had created their own niches for specialty services in their communities.
- All systems had strong community-based constituencies.
- Most systems had made significant investments in information system technology.

Funding Model Committee

The Funding Model Committee analyzed Nashville's indigent care funding structure, researched best practices in other cities and states, and made final recommendations to the Stakeholder Work Team. Several models inform how the city of Nashville could fund indigent care.

TAX-BASED FUNDING

Proponents of tax-based funding generally view access to health care as a right that should not be constrained by income or health status. Nashville General Hospital has historically served low-income populations, especially those people who cannot afford health insurance. A dedicated tax funding model would create a consistent revenue stream for the hospital. If pursued, a surcharge or tax could be incorporated into growing sectors of Nashville's economy, including tourism, restaurant service, and utility bills; or on unhealthy items such as soda.

Cities across the country have benefited greatly from a tax-based funding system. In just four months after the Philadelphia City Council approved a 1.5-cents-per-ounce soda tax on artificially sweetened beverages, it collected \$25.6 million to fund health initiatives in the city. Soda taxes have also been enacted in Oakland, California; Boulder, Colorado; and Portland, Oregon.

HEALTHY SAN FRANCISCO

San Francisco, California

OVERVIEW:

Operated by the San Francisco Department of Public Health, the Healthy San Francisco program helps make health care services affordable to uninsured residents of the city. The program is broad and robust:

- The program is available to all San Francisco residents regardless of immigration status, employment status, or pre-existing health conditions.
- Participants must show proof of residency; be uninsured for at least 90 days; be ineligible for public insurance programs; be living on a combined family income at or below 500% of the Federal Poverty Level; and be over the age of 18.

- Participants may also incur a fee based on their income level, determined by a sliding scale.
- Participants receive comprehensive health services including primary, specialty, mental health, emergency care, hospital care, prescription drugs and substance abuse treatment.
- Each participant receives an enrollment card and selects a medical home for primary and preventive services.
- Specialty care is provided by San Francisco's public hospital and private nonprofit hospitals.

THE PROGRAM IS FUNDED THROUGH A MIX OF SOURCES:

- The city's general fund (\$38 million in fiscal year 2016-17)
- Contributions from private hospitals and medical homes (\$8 million)
- Participant sliding scale fees (\$2 million)
- Employers' payments under the San Francisco City Option Program (\$3 million)

The program also allows employers to add a "Healthy San Francisco Surcharge" to their goods and services to help pay for their employees' access to the program. Restaurants, for example, can add a surcharge of around 4% to a patron's check.

In FY2016-17, an estimated \$50.63 million was spent on Healthy San Francisco:

- The San Francisco Department of Public Health spent approximately \$43.1 million.
- Additional funding of \$38.27 million was provided by a City and County of San Francisco General Fund subsidy. Private community providers reported an estimated \$7.55 million in net expenditures.
- \$4.8 million of this was generated in revenue from Healthy San Francisco.

RESEARCHED FUNDING MODELS

STATE	DESCRIPTION
Tampa, FL	0.5% county sales tax is dedicated to the Hillsborough County Health Care Plan.
San Francisco, CA	0.4% Health San Francisco Surcharge is charged to local restaurant patrons.
Boston, MA	Annual \$50 million budget is comprised of grants, private donations, and third-party billing, especially Medicaid.
Austin, TX	Medical Access Program is supported by a dedicated local property tax.
New York, NY	NYC Care is funded by a \$100 million/year increase to the NYC Health + Hospitals budget, coming directly from the city budget and not requiring any new taxes.
Miami, FL	The operation, maintenance and administration of The Public Health Trust of Miami-Dade County hospitals and clinics are funded by a voter-approved 0.5% sales tax.



THE OUTCOMES OF HEALTHY SAN FRANCISCO HAVE BEEN POSITIVE:

Despite ongoing changes in health care, the Healthy San Francisco program has continued to positively impact the health of its participants. According to the most recent annual report in 2016-2017:

- The percentage of respondents who reported visiting an emergency room in a 12-month period declined since 2008.
- The percentage of respondents who reported delays with receiving care declined since 2008, and the percentage of participants who reported good to excellent health increased.
- The number of uninsured adults aged 18-64 in San Francisco declined from 90,000 in 2010 to 30,000 in 2016.

Enrollees in HSF peaked at 55,000 in 2013 and decreased to 20,000 in 2016, due to citizens gaining access to Medi-Cal under ACA expansion. However, HSF continues to be a major source of access to care for the city's estimated 35,000 undocumented residents. In light of the political landscape, the success of the Healthy San Francisco program has continued to evolve and meet the changing needs of the city's most vulnerable population for ten years.

GAMING-BASED FUNDING: "LOTTERY TAX"

Education systems in the United States have benefited from supplemental funding through state lotteries. Indigent care could similarly benefit. Viewed as a "voluntary tax," many state lotteries allocate funds to K-12 public educational programs or scholarships for higher education. However, eight states direct their lottery revenue to a general fund. The money from the general fund is then redistributed to other areas of the state, including health care. The lottery presents a steady stream of revenue that is consistently growing. The average American spends more money on lottery tickets than reading materials or movie tickets.

In Tennessee, the Tennessee Education Lottery Corporation (TEL) closed the last fiscal year with gross total sales of \$1.73 billion. Due to the growth of the lottery, TEL was able to increase funding to education by 9.1 percent in FY18. This growth has great implications for how beneficial the lottery for Nashville's indigent care system could be if a portion of revenue were redirected towards health care.

In theory, a lottery general fund or specified allocation for health care could support indigent care in Nashville. However, the concept creates obvious complications. It would be difficult to gain approval for state-wide lottery funds to

be partially diverted to a city health care system. Additionally, this approach would run the risk of pitting education against health care funding.

OTHER SOURCES OF REVENUE

HOSPITAL SYSTEM FOUNDATION

Establishment of a private, nonprofit foundation to support indigent care could provide additional support and strength to a stable funding source, such as a tax. Many safety net hospitals across the country operate a foundation within their organizational structures, allowing individual citizens and community organizations to support the hospital financially. Effective foundations have been able to raise millions of dollars that contribute to the care of a hospital's indigent populations.

THE HENRY W. GRADY HEALTH FOUNDATION

Atlanta, Georgia

OVERVIEW:

The Henry W. Grady Health Foundation works with donors, corporations and civic activists to raise money for Grady Memorial Hospital and provide underserved patients with excellent medical care. The foundation is a thriving example of philanthropic efforts that support a safety net hospital:

- In 2017, gifts from annual donors, campaign donors, employees, and sponsors raised \$19.4 million. Gifts came from 150+ organizations and 1500+ individuals.
- The foundation collaborates with other organizations to renovate outdated areas of the hospital and provides naming rights to new programs. For example, The Marcus Foundation, Inc., gave \$20 million to expand the Marcus Trauma and Emergency Center and \$10 million for the Marcus Stroke and Neuroscience Center Multi-disciplinary Outpatient Center.
- Projects are also funded through public provisions. Grady Memorial Hospital is building the Center for Advanced Surgical Services funded as a 50/50 public-private partnership by bonds issued from Fulton and DeKalb counties and philanthropic partnerships.

INDIGENT CARE TRUST FUND (ICTF)

An Indigent Care Trust Fund (ICTF) expands Medicaid eligibility and services, supporting rural and other health care providers, primarily hospitals that serve the medically indigent. An ICTF funds primary health care programs for the medically indigent.

INDIGENT CARE TRUST FUND (ICTF)

State of Georgia

OVERVIEW:

Georgia Department of Community Health established the Indigent Care Trust Fund (ICTF) in 1990 to expand Medicaid eligibility and services; support rural and other health care providers, primarily hospitals which serve the medically indigent; and fund primary health care programs for medically indigent Georgians.

THE ICTF IS AN UMBRELLA PROGRAM

ICTF includes the Disproportionate Share Hospital (DSH) program; nursing home provider fees; Care Management Organization (CMO) Quality Assessment Fees; breast cancer tag fees, ambulance rates, and other initiatives.

ICTF funding allows uninsured people who do not qualify for Medicaid to receive health care from participating hospitals.

BUDGET MANAGEMENT

The Casemix or Activity-Based Funding (ABF) model has proven effective for indigent care. It allocates funding based on the number and types of patients treated and the average cost of treating patients. The purpose of the model is to promote transparency, accountability, and efficiency in government funding.

Casemix or ABF was popularized by the State Government of Victoria, Australia. Victoria uses this model to monitor, manage, and administer the funding of health care provided by public hospitals. It has proven beneficial in focusing on patient care and improving treatment outcomes.

THE PRINCIPLES OF CASEMIX OR ABF:

Equitable Access

- Allocate services in accordance with need for services
- Provide patient choice
- Promote the delivery of appropriate care at the appropriate time

- Facility setting to maximize quantity and quality of health care
- Patient health needs are treated alike (horizontal access equity)
- Patients with greatest needs are treated preferentially (vertical access equity)
- Patient, not provider, focused

Effectiveness

- Increases health care outputs and/or improves health outcomes
- Evidence-based
- Integrated technical efficiency
- Delivers highest quality care for the resources used
- Transparency and accountability
- Auditable sustainability
- Reduces long-term health expenditures

THE STEPS FOR CASEMIX OR ABF INCLUDE:

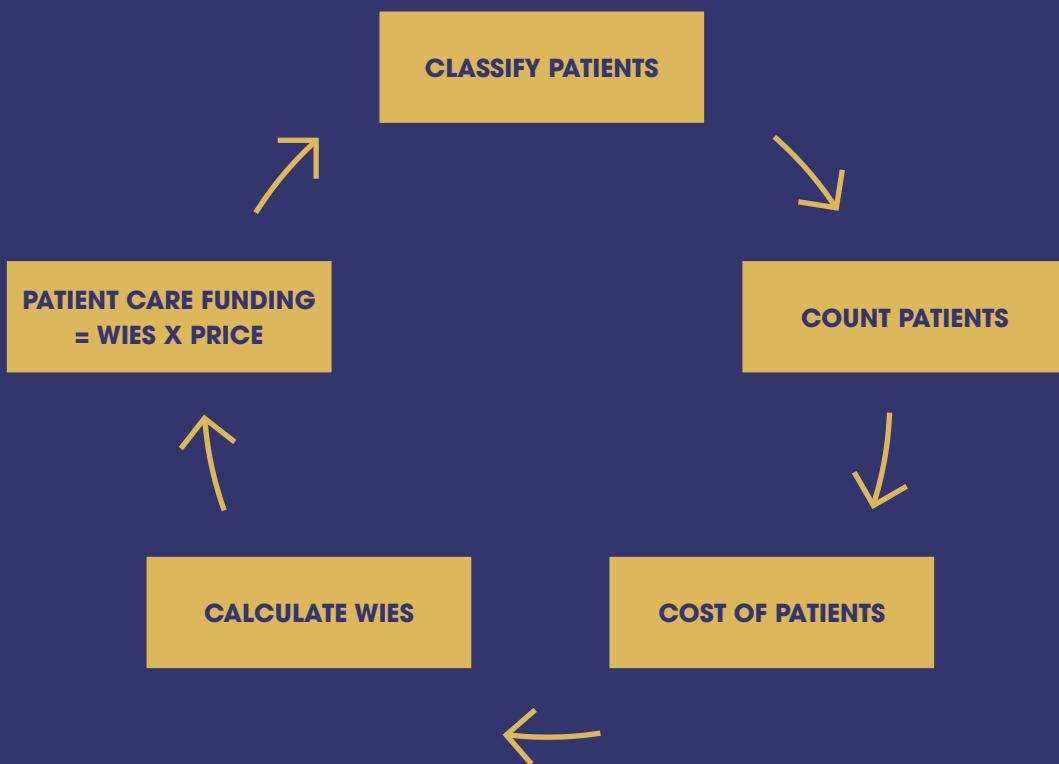
- Step 1: Classify the patients
 - Patients are grouped to Diagnostic Related Group (DRG)
- Step 2: Count patients
 - All admitted patient activity is reported through a hospital dataset
- Step 3: Cost of patients
 - Measure and report costs for each episode of care
- Step 4: Calculate Weighted Inlier Equivalent Separation (WIES) DRG cost (adjusted for patient's length of stay) + co-payment (adjusted for patients with higher costs, such as ICU patients)
- Step 5: Patient care funding = WIES x Price

This calculation provides the total per patient funding need from the government. In order to implement this plan, Nashville would need to examine each service and identify the dollar amount to treat the patient with a specific illness. A history of past patients treated can provide an estimate of how much would need to be allocated for upcoming budget years.

PRINCIPLES OF CASEMIX OR ABF



CASEMIX OR ABF PROCESS



Findings and Recommendations of the Indigent Care Stakeholder Work Team

Today, Nashville's safety net includes nearly three dozen health centers and hospitals that all provide care to the city's medically underserved. There is no "majority stakeholder." Though Nashville General Hospital carries a significant share of the care as the city's only public hospital, no single organization provides the majority of safety net services. More importantly, no single organization oversees the system as a whole. There is no coordinating entity assessing performance, mobilizing resources to fill gaps, or guiding strategic investments by Metro, payers, and health care systems.

Public debate and ambivalence about Metro's funding for Nashville General Hospital often monopolizes conversations about the city's safety net system. Unpredictable funding for Nashville General Hospital has a ripple effect on the stability of health care providers. Previous assessments of the funding mechanism focused on Nashville General Hospital rather than the larger safety net system.

There is, however, a track record of collaboration. The many stakeholders of the Safety Net Consortium of Middle Tennessee have worked consistently over the last 15 years to enhance coordination, streamline systems, fill gaps, and improve outcomes.

The Stakeholder Work Team believes Nashville can build on this foundation to transform and elevate the care that the city of Nashville provides to our medically underserved.

WE RECOMMEND THAT NASHVILLE CREATE A SAFETY NET SYSTEM THAT PLACES PATIENTS AT ITS CENTER AND ACTIVELY INVOLVES THE CITY'S ENTIRE HEALTH CARE INFRASTRUCTURE IN THEIR CARE.

THE GOALS OF THE SYSTEM:

- Optimize access for medically underserved patients (technology, providers)
- Go upstream (incentivize work on social determinants, education, prevention)
- Coordinate care (navigators, resources, methods, standards)
- Connect care (records, sharing appropriately)
- Create a common/shared eligibility process
- Develop focused, collaborative solutions (e.g., strategies for patient categories where lowering cost or improving outcomes is a shared priority)
- Streamline structure and planning (establish a leading entity; create a diverse and competent workforce)

This new safety net system should reflect the vested interest of all stakeholders and build upon the best practices of the most successful indigent care models in the country. It should be viewed as a whole – a shared community investment, not a charity or isolated Metro obligation. At its core, the new system should be rooted in the belief that better health for all Nashvillians will improve the well-being of the whole city.



THE MEMBERS OF THE STAKEHOLDER WORK TEAM BELIEVE:

Nashville must become a healthy city for all who live and work here if we are to maintain our vitality, growth and national profile.

Every resident of Nashville deserves quality health care delivered in an environment that is conducive to wellness, regardless of zip code or ability to pay.

Health care for all must be viewed as a strategic, shared community asset, not as an isolated city investment.

The patient—not the provider—must be the priority and center of care.

To truly be effective, the system must address nutrition, transportation, housing and other social determinants of health that impact a patient's quality of life.

Nashville's entire health care community must be involved in the system to maximize care to our vulnerable residents, leverage resources and eliminate duplication of services.

Nashville's position as a health care capital creates the unique opportunity to optimize the best minds in health care and make our safety net system a model for the nation.

**WE RECOMMEND A NEW SAFETY NET SYSTEM
THAT IS COMPRISED OF TWO CORE ELEMENTS:**

**1 A COLLABORATIVE NETWORK OF
SAFETY NET PROVIDERS**

A collaborative network of hospitals and health care providers across the city of Nashville will deliver integrated, quality, patient-centered care to the uninsured and under-insured, according to their areas of specialty.

- Nashville General Hospital will serve as the hub of the network and focus on delivery of care in three Centers of Excellence: Oral and Systemic Health, Diabetes, and Hypertension.
- The three hospital systems – HCA Healthcare, Ascension Saint Thomas Health, and Vanderbilt University Medical Center – will provide patients with specialty services that are outside of Nashville General Hospital's areas of expertise, such as transplants, certain surgical subspecialties, cardiothoracic surgery, certain subspecialty cardiology, and radiation oncology.
- FQHC and community clinics throughout Nashville will continue to provide safety net services and refer patients for inpatient services to Nashville General Hospital for additional treatment.
- Nashville General Hospital and the city's three major hospital systems should consider the feasibility of a mutually-beneficial agreement under which the private hospitals transfer their low acuity patients to Nashville General.

THE THREE MAJOR HOSPITAL SYSTEMS



Safety Net System Provider Network

INDIGENT CARE NETWORK STRUCTURE

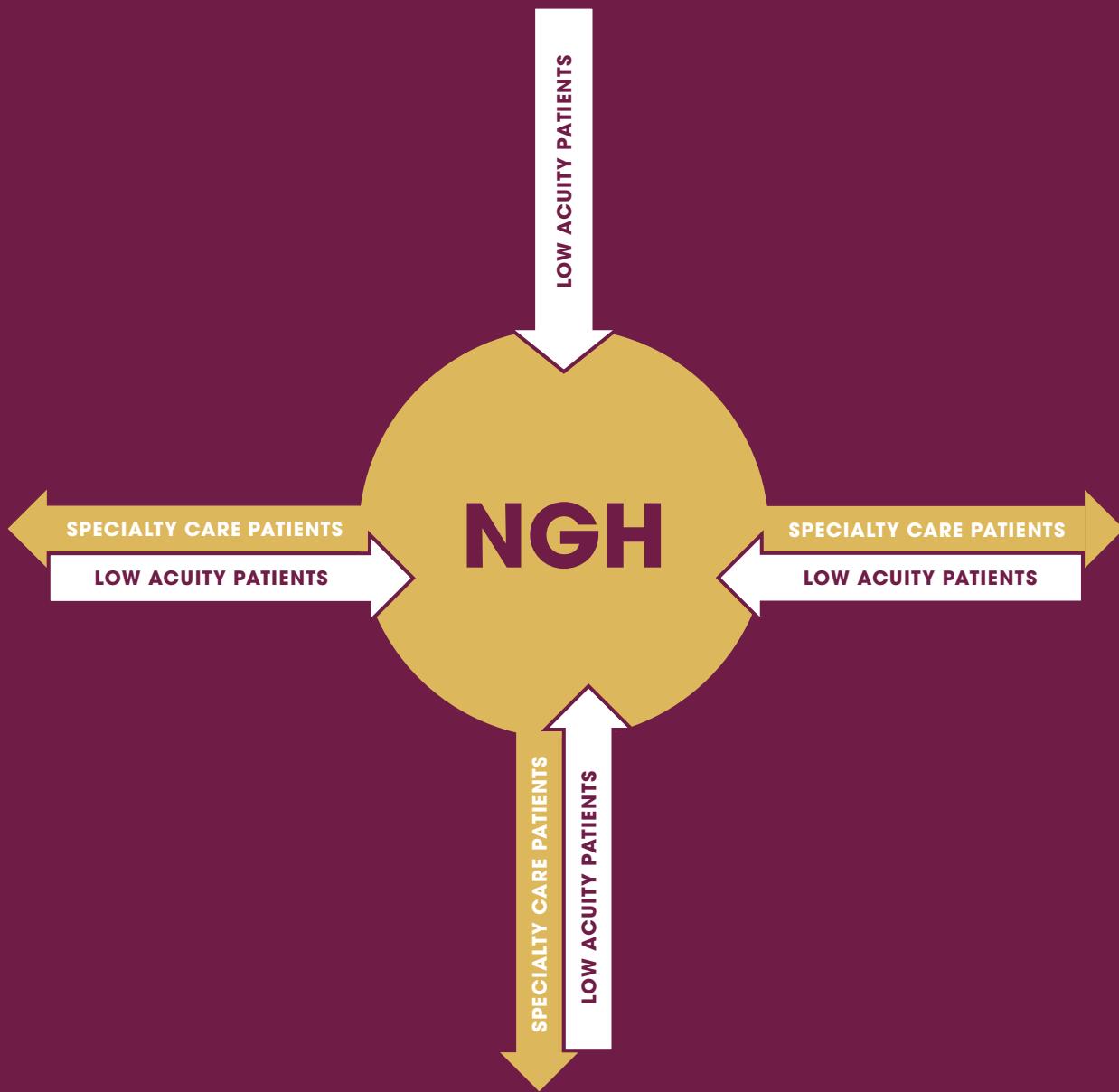
Nashville General Hospital will be the hub where patients receive emergency and primary care services. It will develop three Centers of Excellence in Oral and Systemic Health, Diabetes and Hypertension.

Nashville General Hospital will send its patients who need specialized treatment—surgical subspecialties, radiation oncology, etc.—to Nashville's three major hospital systems.

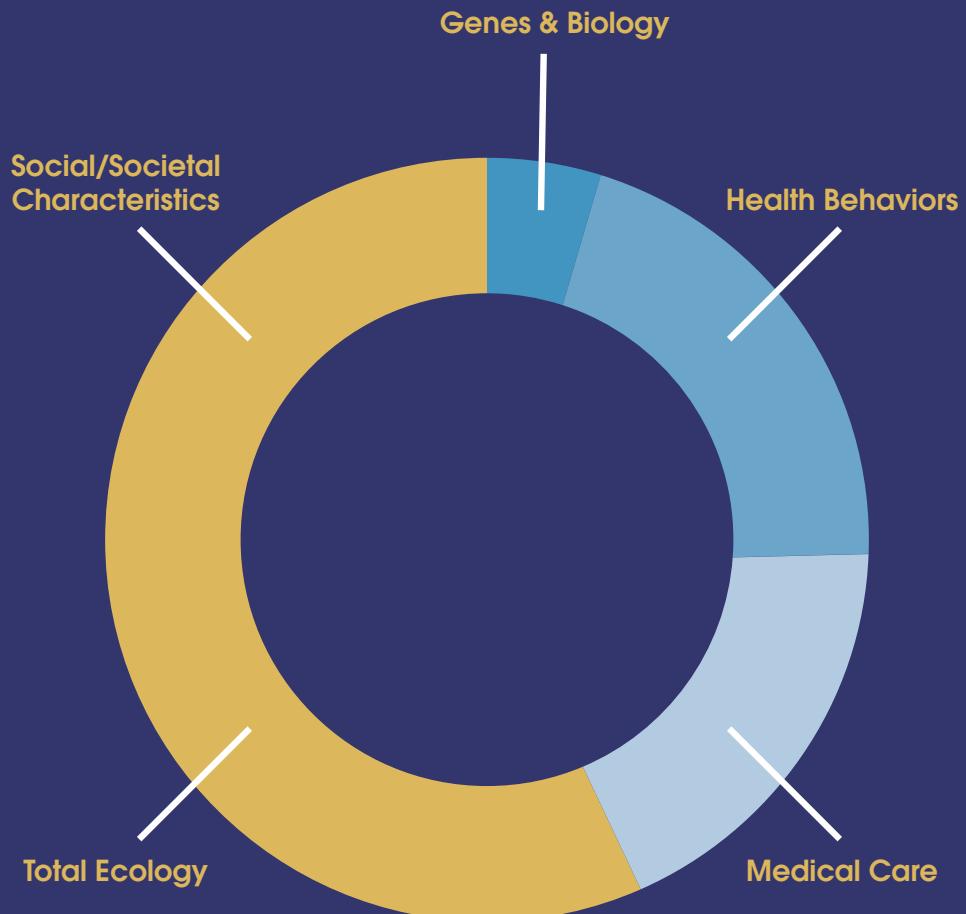
The network will be supported by public and social service agencies (MTA, MDHA, senior centers) that can assist with the social issues that impact patient health, such as insufficient food services, lack of transportation, or homelessness.

Nashville General Hospital and the city's three major hospital systems should consider the feasibility of a mutually-beneficial agreement under which the private hospitals transfer their low acuity patients to Nashville General.

FQHCs, Meharry
Clinics and Other
Safety Net Clinics



DETERMINANTS OF HEALTH



- **Genes and biology:** sex and age
- **Health behaviors:** alcohol use and smoking
- **Social environment or social characteristics:** income and gender
- **Physical environment or total ecology:** neighborhood and population characteristics
- **Health services or medical care:** access to quality health care and insurance

BETTERHEALTH NASHVILLE® – A NEW INDIGENT CARE MANAGEMENT PROGRAM

BetterHealth Nashville® – an indigent care management program – will be formed to coordinate the care of Nashville’s most vulnerable residents, ensuring that their services are adequately funded, treatment is tracked and integrated, and their social needs are addressed.

- The program will be developed and managed by Meharry Medical College, which has been treating the underserved of Nashville for 142 years and has the necessary expertise in medical and oral health care disparities and social determinants of health.
- Patient care will be reimbursed through a newly-formed indigent care fund. Funds will follow the individual patients throughout the network so that their care is covered wherever they receive treatment.
- The new indigent care fund will be created from public and private dollars. It will not tap into the funding already allocated by the city of Nashville to operate Nashville General Hospital.
- Patients will qualify for the system based on predetermined eligibility criteria, including income and insurance status, and can access care from any provider in the network based on their medical needs.
- Patients in the program will be assigned a care coordinator who will help navigate the safety net system, identify the most suitable providers, and manage their ongoing treatment.
- The care coordinators also will help patients identify and address the social challenges that impact their health, including inadequate housing and nutrition, and lack of transportation to and from doctors’ appointments.
- The Data Science Institute at Meharry will create risk profiles for patients and track their treatment throughout the network to decrease redundancy and waste, pinpoint trends, and produce better outcomes.

BETTERHEALTH NASHVILLE® REIMBURSEMENT STRUCTURE

Traditionally, in the city of Nashville, public funding for hospital-based indigent care has been distributed to Nashville General Hospital to treat uninsured and underinsured patients. This funding approach was implemented decades ago because, as the city’s dedicated safety net hospital, Nashville General provides the highest percentage of indigent care to the residents of the city. However, it has not been ideal for Nashville General, other area providers, underserved patients, or taxpayers.

Under the current funding structure:

- Nashville General must be a one-stop health care provider to all its patients, offering a broad range of health care services even if those same services are offered by other hospital providers just a few miles away.
- Other hospitals and clinics must write-off millions of dollars each year that they spend treating uninsured and underinsured patients
- Patients who live far from Nashville General Hospital and do not have access to adequate transportation often choose to forgo treatment and fall through the cracks.

The Stakeholder Work Team recommends the creation of a new indigent care fund that will cover the cost of care for patients who are eligible for BetterHealth Nashville®. We envision that both public and private dollars will be allocated to create the fund, and that it will be separate from the funding the city already provides to operate Nashville General Hospital. Patients who are eligible for BetterHealth Nashville® can pursue care at any provider within the safety net system, and their treatment will be reimbursed out of the new indigent care fund.

This new funding structure creates maximum efficiency for the system. Nashville General Hospital will no longer have to be all things to all people. It can concentrate on the services at which it excels, such as emergency care, primary care, and treatment for diabetes and hypertension; and refer patients with high acuity issues, such as specialized oncology or transplant, to other area providers, whose services will be covered.

The patient becomes the center of the safety net system and all the providers collaborate to deliver the highest quality personalized care.

BetterHealth Nashville®



**Patient qualifies based on
income level, insurance
coverage and other factors.**



**Patient is enrolled in
BetterHealth Nashville® program.**

- Program will be facilitated by Meharry Medical College.
- Patient will be assigned a care coordinator who will help navigate the network and access proper treatment.
- The Data Science Institute at Meharry will create a profile for each patient that includes medical needs, family history, and social determinants of health, including nutrition and transportation.
- Profile will be included in BetterHealth Nashville® database.



Safety Net providers will have access to BetterHealth Nashville® database and can track patient outcomes.

- Database eliminates need for patients to detail their history every time they visit a provider.
- Consistent data and tracking lead to seamless experience for the patient and better health outcomes.

Patient can access care at any safety net provider in the network.

- Patient information will be tracked through the database.
- Funding will follow the patient rather than be allocated to any single provider.

THE ROLE OF DATA SCIENCE

Interoperability between organizations in the safety net system will be essential to ensuring that patients receive consistent and effective care while leveraging resources and eliminating duplication of efforts. The power of data science provides a comprehensive view of a system and makes interoperability attainable as never before in health care.

Doctors and health plans need a complete, holistic understanding of their patients' issues in and out of the health care setting. This information leads to optimal outcomes and appropriate payment. Currently, providers who attempt to exchange information about patients navigate a complex web of technology systems filled with latent data, which captures mere snippets of information about patients at each individual treatment episode. What arises is an incomplete picture of each patient's status.

Meharry Medical College has made a capital investment of \$1 million over the past two years to establish a Data Science Institute to inform student training, patient care, and biomedical research. This initial investment built the technical infrastructure and data ecosystem architecture to establish a "data lake" of clinical data from Nashville General Hospital, Meharry Medical Group, and Meharry's School of Dentistry. Built on open source technology and hosted in a secure cloud, the data lake includes environmental health data (the "exposome"), social determinants of health, and publicly-available behavioral data from social media.

This Nashville General Hospital-Meharry health data ecosystem has proved a foundation for clinical interoperability between Nashville General Hospital and Meharry electronic medical records, enabling the systematic combination of multiple data sets for analysis, reporting, and visualization.

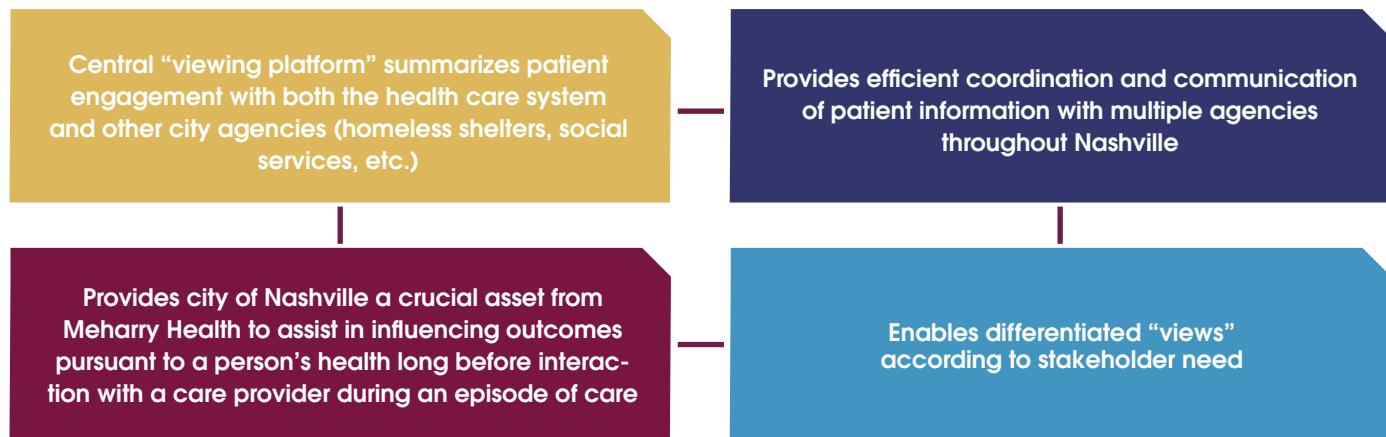
The goal is to make evidence-based decisions answering real-world problems. It makes it possible for multiple providers to track patient progress and predict outcomes, leading to more efficiencies and better care.

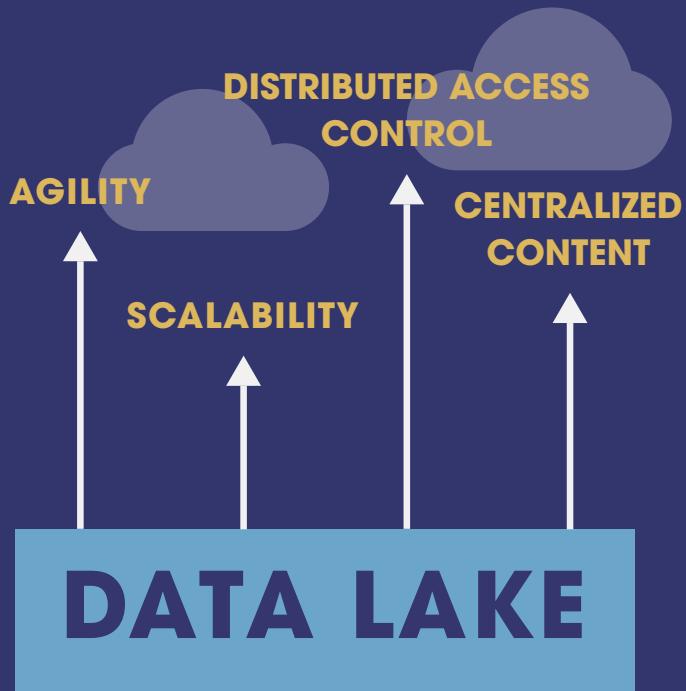
The Stakeholder Work Team recommends that the city of Nashville partner with the Data Science Institute at Meharry to leverage data-driven information for actionable insights on the continuum of care of our most vulnerable citizens. The Coordinated Care Project would provide efficient care coordination and communication with multiple organizations across the city. The Data Science Institute will establish a central "viewing platform" where summaries of patient history with both the health care system and other city agencies (homeless shelters, social services, etc.) can be accessed by relevant stakeholders.

The Data Science Institute at Meharry currently has two tools for leveraging the data lake: the Discover Tool and the Alteryx Tool. The Discover Tool allows users to manage patient cohorts for clinical quality care and inform shared risk with health insurance plans. It is used by academic health science researchers in facilitating clinical translational research from bench to bedside. The Alteryx Tool allows data scientists to look across multi-factorial, structured and non-structured data to develop new predictive models for various disease states.

Meharry continues its institutional investment in the Data Science Institute. The next 12 months will deepen use of the Discover Tool by the Meharry-Nashville General Hospital Health Network for developing predictive models on hypertension, cardiovascular disease, obesity, and type-2 diabetes.

THE COORDINATED CARE PROJECT





KNOWLEDGE DISCOVERY WITH DISCOVER & ALTERYX TOOLS



Implementation

AS THE NEXT STEP IN THE PROCESS, THE STAKEHOLDER WORK TEAM RECOMMENDS THE CREATION OF A NEW NETWORK IMPLEMENTATION TEAM THAT WILL DETERMINE A FISCAL AND OPERATIONAL STRUCTURE TO MAKE THE SAFETY NET SYSTEM Viable, SUSTAINABLE, AND SUCCESSFUL.

Creating and sustaining the proposed safety net system will require thoughtful, thorough implementation and follow-through. There are multiple important considerations: management of the system, funding, reimbursement structure, distribution of responsibility among partners, coordination of care, and capital needs.

Currently, Nashville does not have a central body in place to build the infrastructure for the new system and implement the necessary systemic changes. The Stakeholder Work Team recommends the creation of such an entity.

The new, independent implementation team will determine the best financial and operational structure that ensures patients receive the highest quality care at a manageable cost with measurable outcomes. It will analyze gaps in the current system and initiate improvements. This entity will ensure public accountability and be charged with catalyzing changes that support an integrated health system for Nashville's medically underserved population.

STRUCTURE OF NETWORK IMPLEMENTATION TEAM

The Stakeholder Work Team recommends launching the new Network Implementation Team by May 1, 2019.

Meharry Medical College will consult with the city of Nashville and other health care partners to determine the overall funding structure of the team and a timeline for implementation and delivery.

The new Network Implementation Team should be an outgrowth of the Stakeholder Work Team and include the following elements:

- A governing board carefully composed to represent health system, philanthropy, business, government, and consumer perspectives;
- An operating board substantially based on the current Safety Net Consortium;

- A staff (initially 1-2 positions) that reports to the operating board and is responsible for:
 - Conducting the necessary assessments of the current system;
 - Recommending, coordinating and overseeing system improvements; and
 - Facilitating and mediating solutions across the organizations participating in the system.

Central to the work of the new Network Implementation Team will be the following:

- Conduct a gap analysis of the current system to gather and assess current data on who is in need, where they live and work, and the services required.
- Recommend the most effective funding mechanism for the new system by studying best practices, identifying available resources, and testing various financial models.
- Determine the ideal management structure for the new system by examining best practices and testing various management scenarios.
- Assess the feasibility of bringing on a strategic partner to oversee the consolidation of services at Nashville General Hospital and Meharry Health Clinics to increase efficiency and reduce duplication of services.
- Assess the infrastructural needs of Nashville General Hospital and recommend a capital improvement program that involves either renovating the existing structure or constructing a new one.

INFRASTRUCTURE OF NASHVILLE GENERAL HOSPITAL

A critical topic in the conversation surrounding Nashville General Hospital is the quality of its services and infrastructure, and whether they meet the needs of today's patients of all income levels. As part of its work, the new Network Implementation Team should assess the level of capital commitment needed to raise the hospital's standards by renovating the existing structure or constructing a new one.



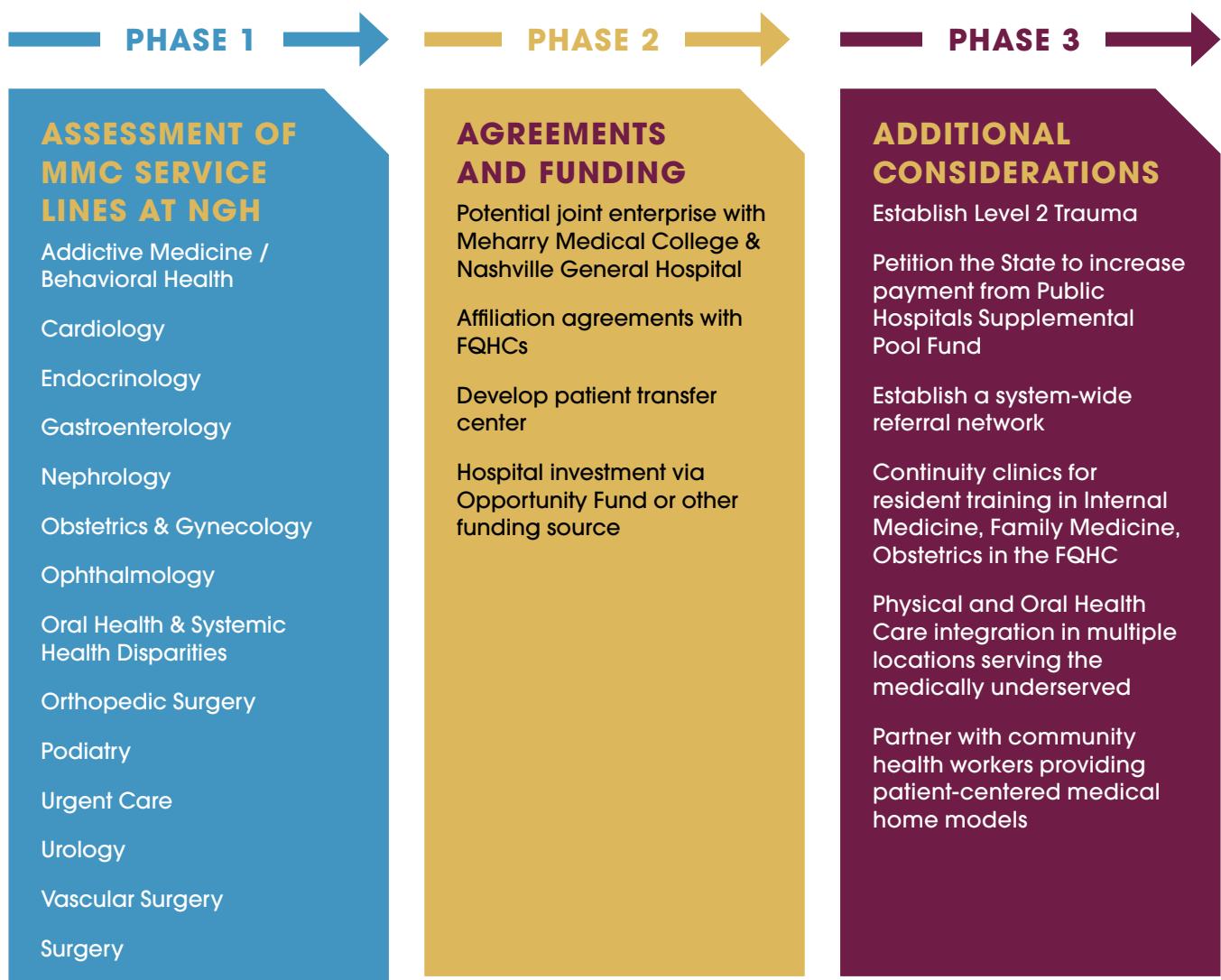


The following are specific points for consideration regarding the hospital infrastructure:

- A new design should meet the needs of today's patient, with an emphasis on emergency and ambulatory services and a smaller inpatient unit.
- The design should support the establishment of three Centers of Excellence at Nashville General Hospital in Systemic and Oral Health, Diabetes, and Hypertension.

- An updated facility could bolster use of Nashville General by Metro employees who can gain incentives for receiving medical treatment at the hospital.
- The city should consider contracting with a strategic partner with expertise in hospital management to help oversee the facility, identify new revenue streams, and share the risk.

NEXT STEPS: PROPOSED IMPLEMENTATION

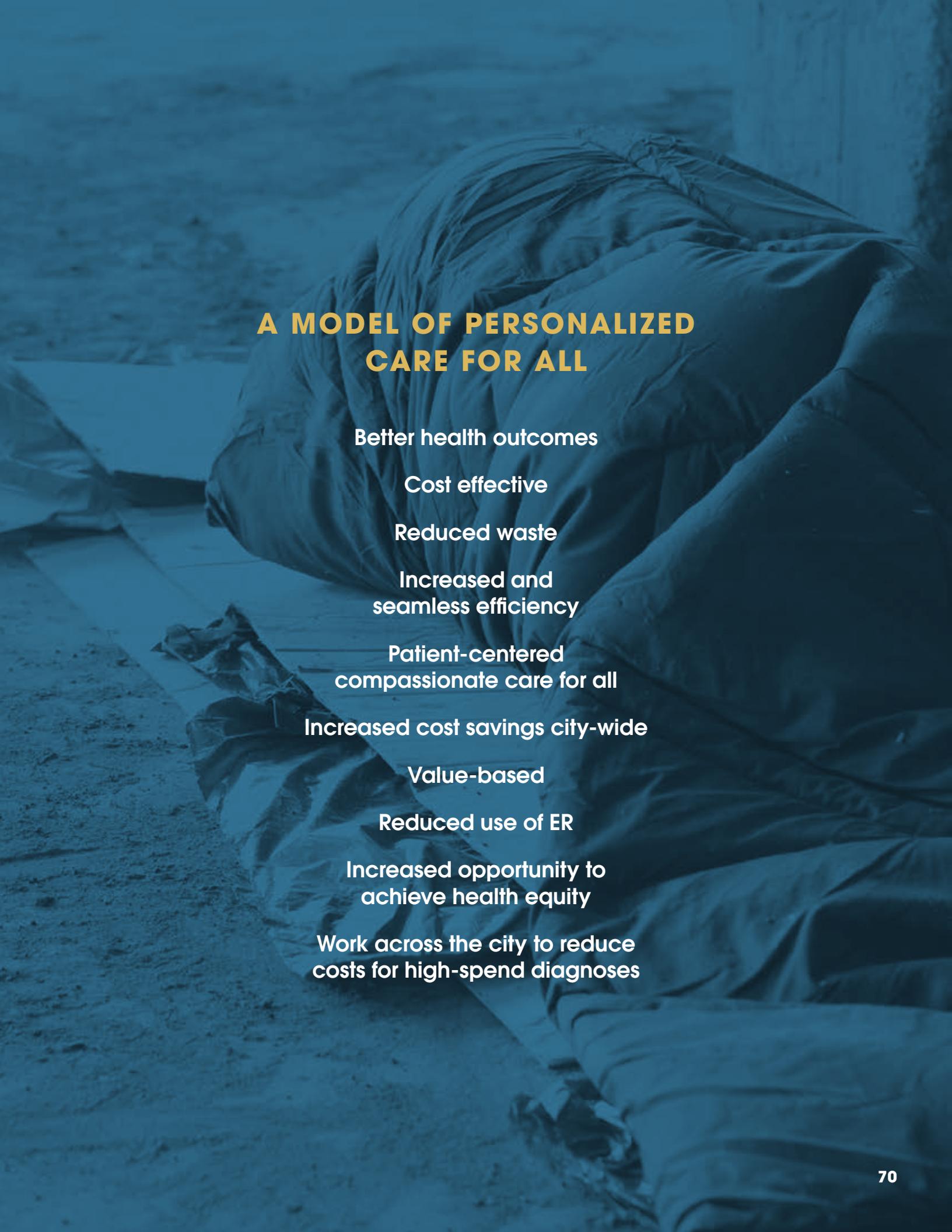


Conclusion

The safety net system in Nashville is not sustainable nor coordinated in its current state. However, the demonstrated strength of the providers and their vested interest in delivering optimal care for the medically underserved illustrates potential for the successful implementation of dynamic system-wide change.

Nashville has the commitment, expertise, and motivation to be a model for indigent care throughout the nation.

Achieving this objective will require a long-term approach, leveraging the will and the creativity of the entire city of Nashville. The Indigent Care Stakeholder Work Team believes such commitment is achievable and looks forward to working toward a new safety net system that will provide the highest quality care to the medically underserved, while ensuring that resources are maximized and costs contained.



A MODEL OF PERSONALIZED CARE FOR ALL

Better health outcomes

Cost effective

Reduced waste

Increased and
seamless efficiency

Patient-centered
compassionate care for all

Increased cost savings city-wide

Value-based

Reduced use of ER

Increased opportunity to
achieve health equity

Work across the city to reduce
costs for high-spend diagnoses



MEHARRY MEDICAL COLLEGE

ACKNOWLEDGEMENTS

The Stakeholder team would like to acknowledge those who contributed to the development of this report over the last year. We owe a great deal of gratitude for their investment of time and talent in formulating the set of recommendations for Nashville's indigent care system.

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